

A STUDY OF THE ROLE OF PRIVATE PATIENTS IN SURGICAL TRAINING PROGRAMS: A RESIDENT'S VIEWPOINT*

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PRIVATE patients are essential, if not always willing, participants in training surgical residents in most institutions. I shall examine the role of private patients in surgical education and propose future directions for their enhanced participation.

MATERIALS AND METHODS

The Beth Israel Medical Center (BIMC) is a 900 bed, voluntary, nonprofit, teaching hospital with a major medical school affiliation. An active surgical residency program annually graduates three chief residents in general surgery, and also offers clinical training for several postgraduate surgical fellows and residents planning careers in surgical subspecialties. Medical students regularly rotate through the service throughout the year.

Annual statistics from major operative procedures performed on the general surgery, plastic surgery, and orthopedic surgery services, broken down into "private" and "service" categories, were reviewed for the 10-year period ending June 30, 1979. Data permitted assessment of the degree of resident participation on the three general surgical services during the six months from January through June 1979. Resident surgeons were asked to characterize their participation in the surgical procedure as a teaching or nonteaching experience.

Each fourth and fifth year resident in general surgery was asked to answer the following questions:

1) Has the predominance of private patients at BIMC had a favorable or unfavorable influence on your surgical education?

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NUMBER OF OPERATIONS PERFORMED ON PRIVATE AND SERVICE
PATIENTS AT BETH ISRAEL MEDICAL CENTER DURING THE 10-YEAR
PERIOD ENDING JUNE 30, 1979.

<i>Year</i>	<i>Private patients</i>	<i>Service patients</i>	<i>Total</i>
7/69-6/70	2,300 (71%)	943 (29%)	3,243
7/70-6/71	2,434 (72%)	964 (28%)	3,398
7/71-6/72	2,427 (72%)	961 (28%)	3,388
7/72-6/73	2,647 (72%)	1,021 (28%)	3,668
7/73-6/74	2,647 (70%)	1,109 (30%)	3,756
7/74-6/75	3,379 (75%)	1,141 (25%)	4,520
7/75-6/76	3,837 (74%)	1,333 (26%)	5,170
7/76-6/77	3,912 (80%)	991 (20%)	4,903
7/77-6/78	4,321 (83%)	891 (17%)	5,212
7/78-6/79	4,448 (83%)	898 (17%)	5,346

2) In general, does the private or service surgical patient receive better care?

3) Do you find it ethically objectionable to participate in a system in which a private patient pays a fee to an attending surgeon to perform an operation and make all of the perioperative decisions, when, in fact, a resident has a major participatory role in the surgery and management of the pre- and postoperative course?

FINDINGS

Over the 10 years surveyed, major operations performed increased from 3,243 in 1969-1970 to 5,346 in 1978-1979, an increase of 65%. During this period, the number of operations performed on private patients nearly doubled, and service cases actually decreased 5% (see table and Figure 1).

During the first six months of 1979, 550 of 1,453 (37.8%) operations performed upon private patients on the three general surgical teaching services were considered a teaching experience by the residents (Figure 2). During this same period, 237 major operations were performed on service patients by the residents with attending surgeon supervision. The distribution of operative teaching experience for residents on general surgery during the first six months of 1979 was, therefore, 69.9% private patients and 30.1% service patients (Figure 3).

Residents agreed that a mixture of private and service patients is a most favorable teaching milieu. Those with prior duty in city and county hospitals, where all patients were "service" cases, indicated that too often the educational experience involved senior residents teaching junior resi-

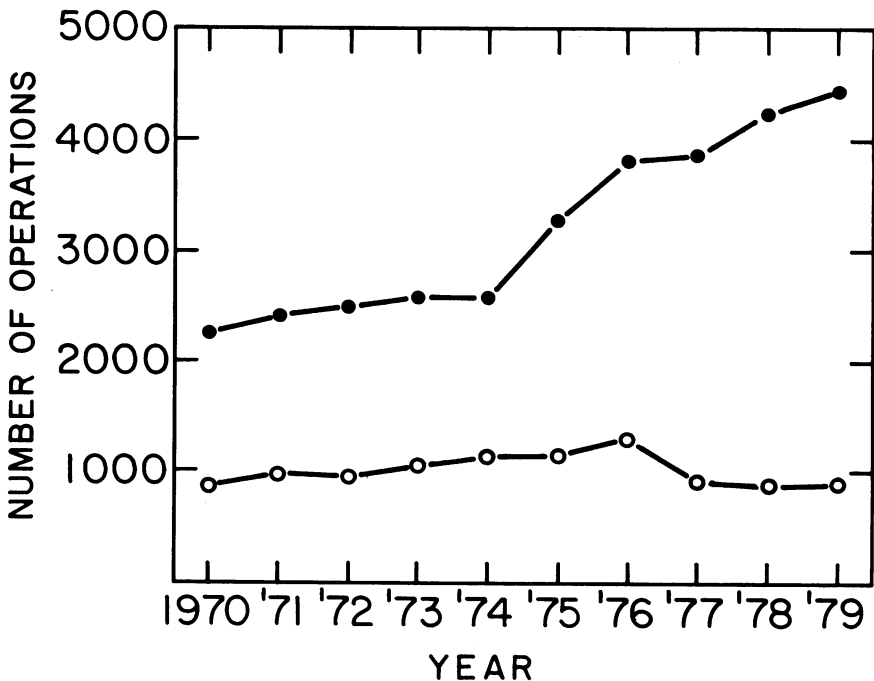


Fig. 1. The number of operations performed on private (—●—) and on service (---○---) patients for the 10-year period ending June 30, 1979.

dents with little or no aid or supervision by the attending staff. Moreover, attending surgeons on service were, for the most part, young and inexperienced. Surgical judgement thus came by trial and error, and acceptable technical skill may never be acquired. On the other side, the obvious danger to house staff education in a private system is that patient care will be accomplished with or without the resident's participation. On balance, large numbers of well trained, experienced surgeons caring for their own private patients in a teaching setting was regarded as a definite advantage, not only to the resident but to the patient, be he "private" or "service." However, reduction in the number of service patients was seen as regrettable for, in management of such individuals, residents initiate the critical decision-making process.

Four of six residents saw no difference in the quality of care afforded private as opposed to service patients. The remaining two gave an edge to service cases because residents tend to follow these patients more closely, and, when there are problems, corrective measures may be instituted more quickly.

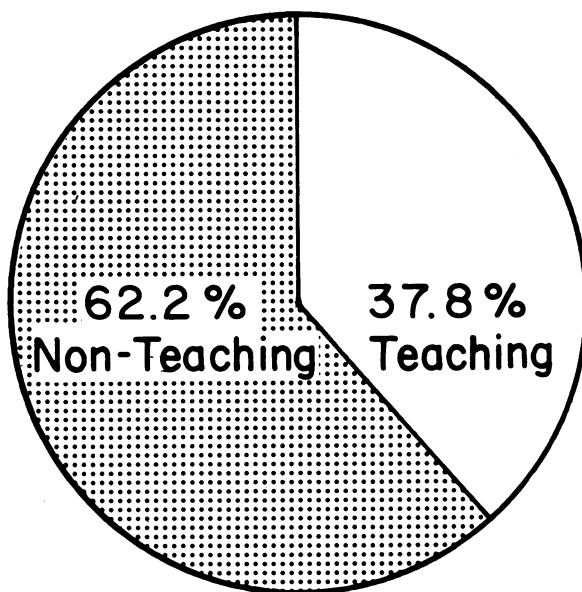


Fig. 2. Operations performed on the private service during the first six months of 1979—"teaching" versus "nonteaching" experience.

Uniformly from the resident's point of view, no ethical conflict exists with respect to resident participation in operations performed on private patients. Most house officers felt that the problem was being overstated. They implicitly assume that the attending surgeon informed the patient of the nature of a teaching hospital and that the patients recognize and accept that residents will be involved in their care with delegated responsibilities both in and out of the operating room. They further hoped that the public is adequately informed as to the advantages of care in a teaching hospital, and most thought, perhaps wishfully, that patients understand and appreciate the need to train new generations of surgeons.

DISCUSSION

If the relations among attending surgeons, private patients, and residents in training were as clearcut as the answers obtained in our survey of senior residents, there would be no need for this symposium. There would not have been a special report to the New York State Assembly titled "Ghost Surgery—a Study of the Practice of Residents Participating in Surgery in New York." The television program *60 Minutes* would not have aired its

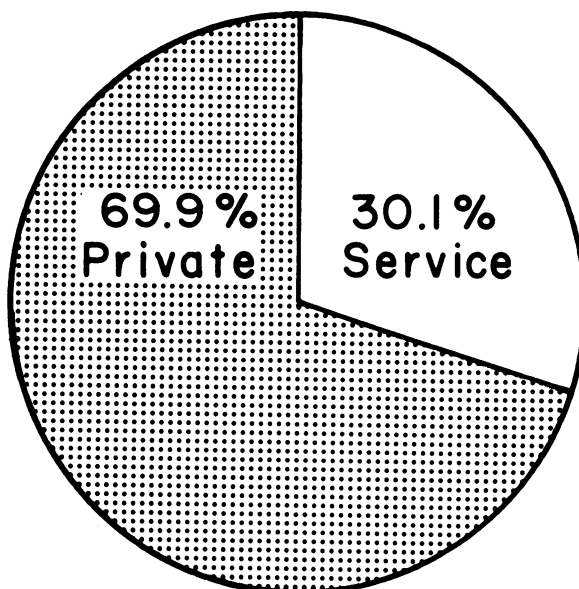


Fig. 3. Distribution of operative teaching experience for general surgery residents by service, for the first six months of 1979.

now famous segment revealing who does the surgery in teaching hospitals. And patients would not ask residents the embarrassing question "Who really did my operation?"

That both the relative and absolute number of service cases has declined underscores the importance of private patients to surgical training programs. While the residents regarded only 37.8% of operations by private attending surgeons on private patients as teaching experiences, the fact is that house officers regularly assist at surgery and participate in pre- and postoperative care of almost every private patient; moreover, private cases are routinely included in teaching rounds. Thus, because about 70% of each individual resident's operating room exposure is with private patients, the importance of this group in surgical training in a voluntary teaching hospital cannot be overestimated.

The most notable factor underlying the decline in numbers of service patients at teaching hospitals is undoubtedly the increasing availability of third-party health insurance in this country.¹⁻⁴ Whether government sponsored, employment related, or privately owned, most Americans are covered by some form of health insurance. Should legislation mandate national health insurance for all citizens, thought by many to be near-at-hand, effects already noted would be greatly enhanced.

Surgery as a specialty is unique in that it requires development of two equally important skills: judgement and technical skill. To develop these skills properly, surgeons in training must be exposed to a large number of patients with a wide variety of clinical problems. They must be afforded increasing responsibility in decision-making, particularly with respect to deciding when and when not to operate. And they must actually perform surgery. Both to protect patients and to develop technical skills of high quality, these operations must be carried out under close supervision by experienced surgeons.

The traditional Halstedian system, based on a sizeable teaching service in which medically indigent patients were the responsibility of the house staff, emphasized close patient contact and resident responsibility. When adopted, it was a major advance over the didactic surgical training prevalent in Europe at the turn of the century. And, by exposing the learner to a number, rather than a single, surgical educator, it was important progress over the then prevalent American system of apprenticeship.

For the first half of this century, teaching wards were composed almost exclusively of immigrants and welfare cases, usually from readily identifiable racial or ethnic minority backgrounds. An atmosphere of increasing social consciousness no doubt contributed to the decline of the Halstedian system. Dr. Francis Moore, addressing this symposium two years ago, mentioned being

. . . a little shocked to hear Dr. Stanley E. Bradley praise the ward patient as good teaching material because of lesser affluence and privilege. For all the virtues of the Halsted residency, we have come to view this type of segregation of a less privileged population, as elitist and essentially a thing of the past. We have come to view a ward service, taken care of exclusively by residents and without guidance from the attending staff as very undesirable.⁴

Dr. Moore went on to propose "the open, acknowledged, one-standard system of post-graduate education," where

. . . all patients who enter the door of the hospital, the emergency ward, or the outpatient department acknowledge that their care will be managed by a team that basically consists of two individuals, a teacher and a learner. . . . The care and responsibility are shared by both members of the team. . . . In the single-standard system, the teacher-learner relation is assumed.

Dr. Moore found it

. . . always a little shocking to visit a teaching hospital in which the older man, the teacher, does the operation from start to finish in an entirely nonsharing mode, only to leave the hospital and go somewhere else or home to bed for the night, leaving 100% responsibility for all other aspects of the patient's care to the learner, . . . obviously an unhealthy and unethical situation.

Is surgery performed by residents safe? One retrospective study⁵ compares elective colon resections carried out by residents under the supervision of attending surgeons with well-matched colectomies performed by the same attending surgeons, with residents as assistants. It reports that the resident surgeons' cases took less time, required fewer blood transfusions, had fewer wound complications, fewer anastomotic leaks, a smaller incidence of small bowel obstruction, and less ileus lasting seven days or longer. The authors stressed this demonstration of the value of a closely integrated team effort but that it would be wrong to conclude that residents alone are capable of performing surgical procedures as well as or better than experienced attending surgeons. However, the data from this study suggest that when residents perform operations under the direct supervision of attending surgeons and when patients are cared for under the same "team" approach, results compare favorably with operations performed by attending surgeons themselves.

No study of surgical education would be complete without reference to the report of the Study on Surgical Services for the United States, sponsored jointly by the American College of Surgeons and the American Surgical Association.⁶ The Subcommittee on Surgical Manpower found that too many physicians perform surgery in the United States. As a consequence, an individual surgeon does not, on the average, perform enough surgery at frequent enough intervals to maintain basic skills. Recommendations to limit the number of surgeons were made. The subcommittee recognized the need for training a certain number of highly qualified, highly trained, and well-motivated young men and women in the practice of surgery. It estimated that this number should be in the range of 1,600 to 2,000 persons per year between 1976 and 2012.

Assuredly, considering the various forces at work, the number of surgical training programs will diminish. At best, this will lead to greater concentration of fine teachers (attending surgeons) and more carefully selected and better motivated learners (surgical residents) in a smaller number of superior institutions (teaching hospitals). The advantages of surgical care at these institutions should be obvious not only to referring physicians but also to patients.

Even now, an intelligent public recognizes the need to train a new generation of surgeons. An important point of the Lifflander Report is that "This study is not to question the necessity of having trainees participate in surgery—only the degree of disclosure is being questioned."⁷ Implicit

in Dr. Moore's one-standard system of surgical education is a partnership between teacher and learner based on mutual benefit and understanding. I propose that the patient, whose importance to the system is obvious and prime, be made an equal partner with the teacher and the learner with all appropriate candor. The advantages to the patient of care in a teaching hospital—where surgical practice represents the highest state of the art—and recognition that resident training is an essential ingredient in the excellence of teaching hospital care, should be presented clearly and accurately to patients. I predict that when patients then exercise their right of choice, they will continue, in large numbers, to select surgeons who operate in teaching hospitals.

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